EXHIBIT 4b

Mr. [redacted] was administered the Boston Naming Test, a word retrieval measure typically used for diagnosing aphasia. Mr. [redacted] was presented with 60 drawings of common objects and asked to name each one. His performance on this measure was similar to others his age, indicating that he does not have any difficulty with word retrieval.

Mr. [redacted] was also administered the Test of Memory Malingering, a measure designed to discriminate between bona fide memory-impaired patients and malingerers. Mr. [redacted] was presented with 50 line drawings of common objects for three seconds each, and was subsequently asked to correctly identify which of two pictures was the one he had previously seen. This task is administered twice and a retention trial followed after a 15-minute delay.

Mr. [redacted] performance on both learning trials and retention trial was consistent with what would be expected given his general level of intellectual functioning. This suggests he was trying to do his best and there was no indication that he was trying to portray himself in an unfavorable light.

Mr. [redacted] was additionally administered the Medical Symptom Validity Test, an assessment for verbal memory with built-in effort testing. It contains two primary effort subtests and two memory subtests. The primary effort measures evaluate whether sufficient effort was made for the patient's memory test scores to be valid or not. This test is very similar to the verbal paired associates subtest from the WMS-IV, but the words are only presented twice. Mr. [redacted] score on this measure was similar to others and suggests that he put forth good effort during this task.

Mr. [redacted] was administered the MMPI-2-RF by Robert Knol, Ph.D. He produced an invalid profile due to the number and severity of symptoms he reported. Despite this, elevations were found on scales that related to issues Mr. [redacted] reported as reasons for seeking treatment. Elevations were found on scales reflecting somatic and cognitive dysfunction complaints, anxiety, aggression, helplessness/hopelessness, ideas of persecution, malaise, gastrointestinal complaints, head pain complaints, and neurological complaints. Please refer to the report by Dr. Knol for complete interpretation of this assessment.

Due to the invalidity of Mr. [redacted]s MMPI-2-RF profile, Dr. Knol recommended the administration of the Structured Interview of Reported Symptoms, Second Edition (SIRS-2). The SIRS-2 is a measure designed to assess deliberate distortions in the self-report of symptoms. Administration of this measure helps to differentiate between purposeful over-reporting and genuine symptoms and problems. Results reflect similar concerns as the MMPI-2-RF. Mr. [redacted] has a clear pattern of scores on the SIRS-2 that is strongly characteristic of an individual with a genuine disorder who is making no efforts to overstate his symptoms. This classification of Genuine Responding has greater than 90% accuracy.

SUMMARY:

Assessment results indicate that Mr. [redacted] overall intellectual ability falls within the average range; however, notable strengths and weakness were discovered by analyzing his performance. While he performed well on a number of subtests, Mr. [redacted] performance on several subtests and measures suggest the presence of auditory memory and processing deficits. These problems can be associated with temporal and frontal lobe damage.

Mr. [redacted] performed better than his peers on tasks of verbal comprehension. His general fund of knowledge is broad and intact. He is articulate and well-educated. It is due to this strength that Mr. [redacted] is able to appear problem-free. He performed similarly to peers on tasks of perceptual reasoning and working memory, but performed significantly lower on tasks involving processing speed. He takes longer than others his age to process information and produce a response. This is a particularly important finding when relating his score in this area to scores in other areas. In fact, the difference between his scores on processing speed and all other areas was so large that it is not often seen in the general population. When differences such as these are seen, it is often associated with a traumatic brain injury.

Mr. [redacted] demonstrated difficulty with both auditory and visual memory. He had difficulty recalling verbally presented information. He demonstrated the ability to learn and improve when provided with multiple trials; however, he was still not able to perform as well as his peers on these tasks. His performance on these subtests measuring auditory memory is below what would be expected given his level of intellectual functioning. Mr. [redacted] also struggled with visually presented information. He was able to reproduce designs presented to him with an average degree of accuracy. However; the time in which he took to complete these designs was far longer than his peers. It was even more difficult for him to remember where designs were placed on a grid. He indicated that he did not feel there was enough time for him to look at the designs. This could be influenced by his deficits in processing speed, whereby he is unable to remember the information because he has not processed it fully in the time allotted. Taken together, this suggests deficits in both speed of processing and memory. His performance on memory tasks is significantly lower than what would be expected given his overall level of cognitive functioning. Again, differences such as these are suggestive of damage to the brain, particularly in the temporal and frontal areas.

Mr. [redacted] visual scanning, number sequencing, letter sequencing, motor speed in drawing lines, visual-motor sequencing, cognitive flexibility, and attention is similar to others his age. He performed better than his peers on measures assessing word retrieval and fluency, which is consistent with findings that indicate his verbal abilities are above average.

Mr. [redacted] effort was assessed through a number of measures. The Advanced Clinical Solutions for the WAIS-IV and WMS-IV indicate that his effort on cognitive and memory tasks was similar to others, indicating he likely put forth his best effort while

completing these tasks, which suggests his scores are valid. His performance on the TOMM and MSVT also indicate that he put forth sufficient effort and was not trying to portray himself in unfavorable light.

Mr. [redacted] endorsed a high number of physical and psychological symptoms, which the MMPI-2-RF indicated was suggestive of over-reporting. The SIRS-2 was administered in order to discern whether his reporting was genuine. Mr. [redacted] reported experiencing symptoms associated with somatic and cognitive dysfunction, anxiety, aggression, helplessness/hopelessness, ideas of persecution, malaise, gastrointestinal issues, head pain, and neurological difficulties. He also expressed feeling uncomfortable in social situations and remarked that he has difficulty with social cues. The SIRS-2 indicated that Mr. [redacted] responses are consistent with an individual who is experiencing a genuine disorder and is not attempting to exaggerate symptoms.

RECOMMENDATIONS:

1. Results of this assessment and history of head injury while playing professional football suggest possible damage to Mr. [redacted] brain. A SPECT scan is recommended to identify impacted areas in order to effectively develop a treatment plan.

2. Results indicate problems associated with auditory and visual memory as well as. It is recommended that Mr. [redacted] participate in a regular neurofeedback program and utilize programs designed to improve these areas of deficit such as Lumosity.

3. Mr. [redacted] has acknowledged experiencing depressive symptoms and anxiety. At times he has felt helpless and hopeless. He endorsed having difficulty with aggression. He has also become socially isolated. It is recommended that he attend individual therapy in order to process his emotions and learn more effective coping skills. Therapy can help him manage aggression. Additionally, Mr. [redacted] would benefit from group therapy to assist him in improving his social skills and work on building trust in others.

4. Mr. [redacted] also indicates a number of somatic complaints. It is recommended that he consult with a physician and/or physical therapist to address long-standing physical injuries.

Laura Hopper, Ph.D.
Clinical Psychologist PSY25788

MMPI-2-RF Report

[redacted]

December 29, 2014

Information in this report is based upon the author's personal interview with the subject and upon responses given to the MMPI-2-RF which generated the computer-assisted *Interpretive Report* (Pearson – PsychCorp). Information taken directly from the above mentioned Interpretive Report is shown in italics in this text.

Brief Social

The client is a 33 yr old male who comes into treatment from his home in the San Diego, , California, area. The client was born in Jamaica Queens, New York. He states that the household moved frequently as he was growing up... but he reports that most of his youth was split between living in Washington state and Southern California. He was born into a household which featured his mother and his father. His parents divorced when he was nine years old. He has a younger brother and an older sister. The patient states that there was no abuse in the household in which he was raised, though he reports some verbal threats from parents along the way.

The subject married at age twenty-seven years. It was the first marriage for both. They continue to be married. They have a four year old son. Also in the household is a sixteen year old daughter who is from an earlier relationship on the part of the patient.

The client states that he maintains communication with his father and with his two sibs.

In terms of sources of emotional / social support, the client easily names six individuals in his current life space.

Brief Educational /Vocational

The client reports that he has a bachelor's degree from Stanford University.

Our patient states that his employment history consists entirely of profession football. He cites 2004 to September, 2012, as the time span of his career. He played Defensive Lineman.

The client reports that he currently has some disability income from his NFL classification "Line of Duty." He states that he is in the process of applying for Social Security Disability.

Brief Medical and Behavioral Health History

The subject cites a long list of sports-related injuries including damage to: Knees. Shoulders. Lumbar and cervical vertebrae. Elbow. Hands. Thumbs. Hip. and more. He reports also experiencing "flash knock outs" stemming from blows to the head.

The client states that he has never made a suicide attempt. He denies SI / HI presently. He reports never being hospitalized for a psychiatric reason. He states that he has never had any outpatient mental health treatment. He states that he is aware that he has suffered from anxiety.

The client reports that he has experienced beverage alcohol and some recreational [street] drugs such as one might experience while attending college. He comments that he does not use alcohol or drugs any longer.

The client states that medications he currently uses include Norco, Flexeril, generic Ambien and an anti-inflamatory creme.

Legal

Our subject states that in 2006 he was charged with domestic-violence-type behavior against the woman who would eventually become his wife. The client states that the record of this incident has since been "expunged."

Findings from the MMPI-2-RF

This MMPI-2-RF protocol is invalid and uninterpretable due to indications of over-reporting.

This protocol is invalid because the test taker reported a considerably larger than overage number of symptoms rarely described by individuals with genuine, severe psychopathology. This level of infrequent responding is uncommon even in individuals with genuine, severe psychopathology....

He also provided a very unusual combination of responses that is strongly associated with non-credible memory complaints. This combination of responses is uncommon even in individuals with significant emotional dysfunction. In addition, he provided an unusual combination of responses that is associated with non-credible reporting of somatic and/or cognitive symptoms. This combination of responses may occur in individuals with substantial medical problems who report credible symptoms, but it could also reflect exaggeration. Scores on the somatic scales – Somatic Complaints (RC1), Malaise (MLS), Gastrointestinal Complaints (GIC), Head Pain

Complaints (HPC), and Neurological Complaints (NUC) – and the Cognitive Complaints (COG) scale should be interpreted in light of this caution.

Despite the interpretation caution, the named scales cited in the above paragraph are identified herein because these scales generated the majority of the very high T-scores.

- ***Suicidal/Death Ideation***
- *Helplessness/Hopelessness*
- *Anxiety*
- *Ideas of Persecution*
- *Aberrant Experiences*
- *Substance Abuse*
- *Aggression*

Given the above findings, this author recommends administering the SIRS assessment to this client.

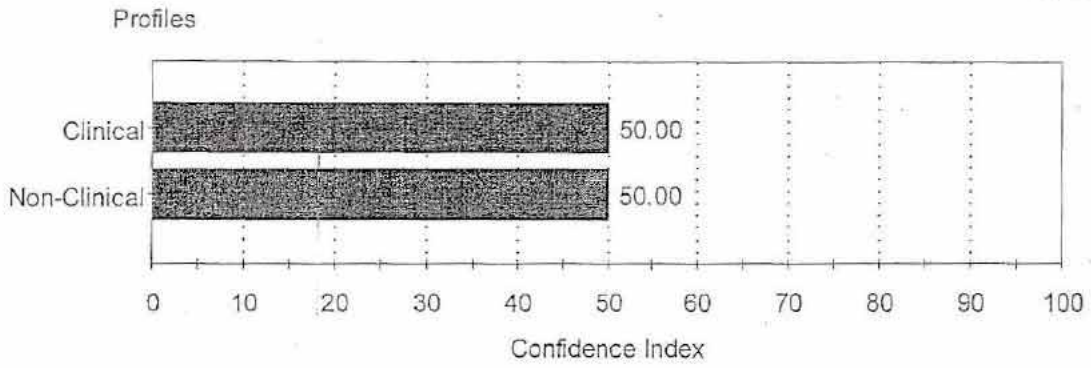
For this Center's official diagnosis pertaining to this patient, please see our psychiatrist's notes on this patient.

Robert Knol, Ph.D.
Licensed Psychologist PSY 19904

12-29-14

Confidence Index Associated with ADHD Assessment

The following graph shows [redacted] Confidence Index for the clinical and non-clinical profiles.



No Decision, Confidence Index = 50.0%

The CPT discriminant function indicates that there is an equal chance that this profile belongs to a clinical or to a non-clinical individual. Therefore, no suggested classification is given.

The Confidence Index should always be reviewed in relation to results on the remaining CPT II measures. When the Confidence Index falls close to 50 (providing no decision), however, there is a heightened need to examine all individual index and measure scores, and to consider the inter-relationships between them.

The authors of this assessment instrument caution against assigning a diagnosis of ADHD or dismissing such a diagnosis singularly based upon this one index.